Toward integrated medical resource policies for Canada: 12. Looking back, looking forward

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This is the 12th and final article in the series[1-11] based on the report *Toward Integrated Medical Resource Policies for Canada*,* prepared for the Federal/Provincial/Territorial Conference of Deputy Ministers of Health.[12-14] In it we look back at our recommendations for "next steps" and comment briefly on what has been happening since the release of the report. We will describe our general sense of where we see progress and where we feel it has been wanting; the selected examples are not meant to be exhaustive. We have not been asked to do any follow-up monitoring of new initiatives, nor have we attempted to do so.

Beyond "Barer-Stoddart"

In our report we went to some lengths to emphasize that we had "discovered" very few, if any, physician-resource problems that were not already widely recognized, nor had we developed large numbers of novel policy approaches. Indeed, one of our enduring impressions was how long most of the problems have existed and how often many of the more fruitful policy avenues have been recommended over the past 20 years. Thus, our report was neither the first word nor the last: it represented a "midterm review" and analysis of what needed to be done to escape the quicksand.

The report offered a framework and avenues for reform but did not attempt to develop the detailed blueprint. Accordingly, we closed with a discussion of what seemed to us to be critical next steps.[15] Because some of our policy options involved the creation of new roles and responsibilities and many others required the redefinition of existing roles, we felt that one of the next steps was to develop a "roles matrix" in which the implications for the roles of all affected parties would be identified for discussion. Alongside such an analysis a more detailed "critical path" for policy development and implementation would need to be created.

However, we also felt that more detailed work on either of these fronts would be premature until some consensus or decision had been reached on the elements to be included in a national or interprovincial strategy. This would require feedback on the themes, principles, analysis and recommendations contained in the document from not only groups and individuals whom we interviewed but also other parties affected. The feedback would be important in determining the form of and participants in a national strategy and again in the more detailed development involved in future stages.

To move beyond reactions and suggestions all parties will need to identify and accept the principles on which successful policy reform could be based. We see at least seven of these: (a) a clear statement of policy objectives that everyone agrees on, (b) respect for different sources of legitimacy in

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representing the public interest, (c) restriction of the role of experts to the areas of their expertise, (d) alignment of private interests with the collective goals of a largely publicly financed system, (e) the opportunity for representation and participation of the parties affected by the proposed changes, (f) establishment of significantly stronger accountability mechanisms and (g) a primary focus on improving the effectiveness of medical care or other health-enhancing activities rather than on expenditure control for its own sake.

In addition, we noted the need for clear evidence of a commitment from those purporting to catalyze and lead change. If provincial governments are to play this role they will be expected to provide clear indications of the directions and targets of change and demonstrate consistency and resolve in their own policy decisions. They will also be expected to negotiate in good faith the key roles and responsibilities for other stakeholders.

Considerable time and effort will be needed in these negotiations and in the synchronization of policy development and formulation in different areas of the physician resources sector. Problems tackled in isolation will not be solved. Once consensus about the objectives and key elements of a reform package is reached, stakeholders will need to understand that change in some form will occur, even if they choose not to participate. As far back as 1973 Evans[16] warned specifically about this:

> It cannot be overemphasized that the success of the evolutionary and participatory approach to the development of a system of health services depends in large measure on the initiative and responsiveness of groups outside government. Unless the [stakeholders] participate responsibly and responsively, there is little doubt that the resulting pressures for cost control alone will force a more doctrinaire approach from government, with conformity, rigidity, and restraint replacing pluralism, flexibility, and incentives.

Finally, the progress of any movement toward a national strategy must itself be monitored against policy milestones set in advance. In addition, flexibility and the capacity for adjustment must be built into the strategy; there are no permanent solutions to problems in this sector.

Monitoring progress

About 17 months has elapsed since the release of our report. Volumes have been *said* and *written* during that period, in response to the report itself but also as part of a continuing movement on various policy fronts that was already under way at the time of our work. Much less has been *done*, let alone *evaluated*. However, this should not be cause for pessimism, at least not yet. Indeed, the process of policy change is one in which progress is commonly measured over a decade rather than over months or years.[17] On the other hand, the policy changes will not appear as manna: they will require discussion, negotiation, broad participation, commitment and, in the end, political will. Many of these can be monitored over periods much shorter than a decade.

While we were conducting our interviews and preparing our report we were encouraged to find that the pace of just this sort of discussion and negotiation appeared to be quickening: several important conferences were sponsored by the CMA to address issues such as physician supply, stakeholder conflicts within the medical profession and physician accountability; the Association of Canadian Medical Colleges sponsored a symposium on the social responsibility of academic health sciences centres; numerous other national, regional and local organizations held events or spearheaded policy initiatives, the purposes of which resonated with the themes of our project; and provincial medical associations began warming to the promulgation of clinical guidelines, and provincial licensing bodies began to give quality assurance and maintenance of competence programs more serious consideration. These moves revealed the widespread concern for the development of constructive action. What was missing was a display of any vision or galvanizing leadership for the sector as a whole and as a *system* and, for the most part, an effective means of coordination along the policy continuum laid out in our report.[3]

Since then the pace has quickened, with some encouraging signs of coordination, structure and overall leadership and responsibility. The Conference of Deputy Ministers of Health agreed to a joint release of the report and to invite stakeholders to respond. Although not without its problems this release and call for response was taken seriously and elicited volumes of thoughtful and informative material. Some of these responses were collated (e.g., by the federal government and by the CMA), and we presume that provincial deputy ministers of health reviewed the responses to their individual requests. However, we are unaware of any coordinated attempt to review and synthesize all the responses in an effort to distil common themes and concerns or to summarize reactions and alternatives by geographic region and stakeholder.

A number of national organizations developed workshops or miniconferences so that the various interested parties could share views and concerns and develop common ground for a response. (Two examples were a CMA meeting in September 1991 and the 11th Biennial Conference of Specialties,

sponsored by the Royal College of Physicians and Surgeons of Canada, in January 1992.) This entire process culminated in the June 1992 National Conference on Physician Resource Management, one of the main objectives of which was to develop stakeholder consensus for a number of key areas: quality improvement, underserved populations, the role of academic medical centres, postgraduate medical education and alternative service delivery. A summary was released immediately after the conference,[18] and the organizers have commissioned a full report.

Perhaps the landmark event in 1992, close on the heels of the "response period," was the January 1992 Provincial/Territorial Conference of Ministers of Health, in Banff, Alta. The document released by that group, *Strategic Directions for Canadian Physician Resource Management*,[19] represented a rare consensus statement from the ministers. It embraced the principles and key policy avenues articulated in our report. In our view it represented an important indication of common intent and commitment that set out directions, objectives and broad strategies under which individual and coordinated initiatives could evolve. This commitment was reaffirmed at the most recent meeting of the ministers.[20]

Recent, more specific policy initiatives have indicated a new interest in and commitment to coordination and collaboration. Provincial ministers of health have agreed to seek a reduction in the number of first-year undergraduate medical positions to about 1600 and to implement a phased reduction of 10% in the number of funded postgraduate training positions. The National Coordinating Committee for Postgraduate Medical Training has been established as an advisory committee to the Conference of Deputy Ministers of Health. Its mandate includes making recommendations on the rationalization and redistribution of specialty and subspecialty training positions and on the funding of postgraduates. How well it is able to fulfil this mandate remains to be seen.

Far less evident to date are detailed implementation plans. For example, we are unaware of any specific plans for reaching the national undergraduate target of 1600[21] or the timing and details of the reduction in postgraduate training positions. Furthermore, the necessary complementary initiatives in the areas of residency service replacement, foreign medical graduates, and complementary and substitute personnel training[4,7-9] are lacking. This may reflect a more general absence of the policy "critical path" that we believe is an essential building block for any coordinated set of initiatives. If no one has analysed the timing, interaction and impact of the initiatives it will be extremely easy and tempting to "cherry pick." Without a systematic effort to identify logical temporal sequencing and critical interdependencies, to develop and negotiate key roles and responsibilities, and to create the bodies necessary to oversee the coordination of new initiatives, a haphazard collection of policies will almost certainly emerge. The likelihood that they might meet overall national sectoral objectives seems remote.

Some final thoughts

One of the great difficulties in developing and implementing a set of strategic policy reforms as extensive as those we have set out is that their success depends so critically on the delicate interweaving of many individual initiatives in areas controlled by many different players. In the end, policy change is developed by individuals, negotiated among individuals and affects individuals. Players change frequently, and with each change comes a loss of institutional history and a threat to shared commitments, which then must be rebuilt.

This is most true for the provincial politicians (and their deputies) who initiated this entire process. Given that significant policy shifts occur only over decades, whereas political cycles run for 4 to 5 years or less, it is a wonder that one ever sees such shifts. The provincial and territorial ministers of health have developed a collective consensus on what they feel needs to be done and a commitment to work together to achieve it, but the staying power of this extraordinary, coordinated political will may be tested in the years to come. The reforms contemplated here will not be completed within any electoral cycle, or perhaps even cycles.

Thus, we come full circle to the need for the ministers of health to develop a critical path for policy development and a roles matrix. Only if all key participants are clear on the collective objectives and on how best to stage and coordinate policy change in this sector can the process of negotiating roles and responsibilities begin in earnest. Along with those roles and responsibilities there should be clear timetables, milestones and reporting expectations. For example, the Conference of Deputy Ministers of Health might request progress reports from one or two groups responsible for particular policy areas at each of their semiannual meetings. Without some such attempt to oversee the coordination of policy change and monitor progress against the critical path, increased policy activity by each jurisdiction in the many areas requiring attention may simply lead to chaos.

In the end, the achievement of the reforms outlined in our report will require the commitment and participation of a broad mosaic of participants. We believe that the most sensitive and innovative solutions to the problems of implementation and adjustment will be found by those closest to the

problems, but only if they are committed to the search, feel that important objectives are being achieved collectively and in a rational, coordinated fashion and believe that they are being treated fairly.

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Conferences

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Mar. 14-18, 1993: 4th International Conference on the Reduction of Drug Related Harm (sponsored by the Dutch Ministry of Welfare, Health and Cultural Affairs, the Municipality of Rotterdam and the *International Journal on Drug Policy*)
Rotterdam, the Netherlands
Conference Secretariat, Essenlaan 16, PO Box 4193, 3006 AD, Rotterdam, the Netherlands; tel 011-31-20-0-10-452-51-66, fax 011-31-20-0-10-452-07-71

Mar. 18-23, 1993: Association for Applied Psychophysiology and Biofeedback 24th Annual Meeting
Los Angeles
Joette Cross, director of meetings, Association for Applied Psychophysiology and Biofeedback, Ste. 304, 10200 W 44th Ave., Wheat Ridge, CO 80033; tel (303) 422-8436, fax (303) 422-8894

Mar. 19-21, 1993: Canadian-Trinidad and Tobago Medical Convention (sponsored by the Trinidad and Tobago Medical Association)
Trinidad and Tobago
Medical Staff Office, Queensway General Hospital, 150 Sherway Dr., Etobicoke, ON M9C 1A5; tel (416) 253-2938, fax (416) 253-0111

Mar. 25-26, 1993: Memory in Normal Aging and Dementia (sponsored by the Rotman Research Institute of Baycrest Centre)
Toronto
Education Department, Baycrest Centre for Geriatric Care, 3560 Bathurst St., Toronto, ON M6A 2E1; tel (416) 789-5131, ext. 2365

Mar. 26, 1993: Nutrition and Women's Health — New Perspectives
Toronto
Vitamin Information Program Symposium, Hoffmann-La Roche Limited, 2455 Meadowpine Blvd., Mississauga, ON L5N 6L7; tel (416) 542-5610

Mar. 29-31, 1993: Excellence in Medical and Scientific Writing
Toronto
McLuhan and Davies Communications, Inc., 167 Carlton St., Toronto, ON M5A 2K3; tel (416) 967-7481, fax (416) 967-0646

Apr. 4-7, 1993: Focus on Children — Protecting our Future
Calgary
Canadian Organization for Victim Assistance/Child Find Alberta Conference, 256 Ranchridge Crt. NW, Calgary, AB T3G 1W5; tel (403) 239-2920, fax (403) 270-8355

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